FOR OHF USE

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0042176

Facility Name: Renaissance At Hillside

Address: 4600 Frontage Road (Number) Hillside (City) 60162 (Zip Code)

County: Cook

Telephone Number: (708) 544-9933 **Fax #** (708) 544-9966

IDPA ID Number: 363980624001

Date of Initial License for Current Owners: 06/30/97

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/03 to 12/31/03 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) Noshir R. Daruwalla, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance At Hillside # 0042176 Report Period Beginning: 01/01/03 Ending: 12/31/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 06/06/03

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	166	Skilled (SNF)	168	61,008	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	166	TOTALS	168	61,008	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	42,803	6,282	7,035	56,120	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	42,803	6,282	7,035	56,120	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.99%

D. How many bed-hold days during this year were paid by Public Aid?
679 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 06/30/97

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 06/30/1997 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 32 and days of care provided 7,035

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/03 Fiscal Year: 12/31/03

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance At Hillside # 0042176 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger: Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	273,707	63,430	8,440	345,577		345,577		345,577			1
2	Food Purchase		260,400		260,400		260,400	(763)	259,637			2
3	Housekeeping	235,277	33,064	(23,402)	244,939		244,939		244,939			3
4	Laundry		11,357		11,357		11,357		11,357			4
5	Heat and Other Utilities			170,991	170,991		170,991	(9,097)	161,894			5
6	Maintenance	18,868	18,630	41,090	78,588		78,588	1,280	79,868			6
7	Other (specify):*							(23)	(23)			7
8	**TOTAL General Services**	527,852	386,881	197,119	1,111,852		1,111,852	(8,603)	1,103,249			8
	B. Health Care and Programs											
9	Medical Director			18,750	18,750		18,750		18,750			9
10	Nursing and Medical Records	2,064,993	187,083	103,831	2,355,907		2,355,907	129	2,356,036			10
10a	Therapy		36	6,755	6,791		6,791		6,791			10a
11	Activities	104,320	10,669	2,459	117,448		117,448		117,448			11
12	Social Services	102,620		4,320	106,940		106,940		106,940			12
13	Nurse Aide Training			590	590		590		590			13
14	Program Transportation			1,193	1,193		1,193	2	1,195			14
15	Other (specify):*							15	15			15
16	**TOTAL Health Care and Programs**	2,271,933	197,788	137,898	2,607,619		2,607,619	146	2,607,765			16
	C. General Administration											
17	Administrative	137,979		416,690	554,669		554,669	(295,802)	258,867			17
18	Directors Fees											18
19	Professional Services			118,031	118,031		118,031	(20,936)	97,095			19
20	Dues, Fees, Subscriptions & Promotions			120,988	120,988		120,988	(89,586)	31,402			20
21	Clerical & General Office Expenses	130,517	34,525	260,400	425,442		425,442	(224,231)	201,211			21
22	Employee Benefits & Payroll Taxes			574,001	574,001		574,001	(35,813)	538,188			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,283	3,283		3,283	522	3,805			24
25	Other Admin. Staff Transportation			148	148		148	179	327			25
26	Insurance-Prop.Liab.Malpractice			210,166	210,166		210,166	371	210,537			26
27	Other (specify):*							28,132	28,132			27
28	**TOTAL General Administration**	268,496	34,525	1,703,707	2,006,728		2,006,728	(637,165)	1,369,563			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,068,281	619,194	2,038,724	5,726,199		5,726,199	(645,622)	5,080,577			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Renaissance At Hillside #0042176 Report Period Beginning: 01/01/03 Ending: 12/31/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			122,944	122,944		122,944	157,971	280,915			30
31	Amortization of Pre-Op. & Org.			7,522	7,522		7,522	3,632	11,154			31
32	Interest			149,671	149,671		149,671	549,699	699,370			32
33	Real Estate Taxes			340,465	340,465		340,465	(7,010)	333,455			33
34	Rent-Facility & Grounds			1,120,862	1,120,862		1,120,862	(1,112,313)	8,549			34
35	Rent-Equipment & Vehicles			7,881	7,881		7,881	5,474	13,355			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,749,345	1,749,345		1,749,345	(402,546)	1,346,799			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	8,651	326,501	350,965	686,117		686,117	(53)	686,064			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			91,512	91,512		91,512		91,512			42
43	Other (specify):*	138,833			138,833		138,833	(138,833)				43
44	**TOTAL Special Cost Centers**	147,484	326,501	442,477	916,462		916,462	(138,886)	777,576			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,215,765	945,695	4,230,546	8,392,006		8,392,006	(1,187,054)	7,204,952			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance At Hillside # 0042176 Report Period Beginning: 01/01/03 Ending: 12/31/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(103,509)	30		9
10	Interest and Other Investment Income	(22)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(291)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(82)	21		18
19	Entertainment	(5,045)	21		19
20	Contributions	(16,415)	20		20
21	Owner or Key-Man Insurance	(35,813)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(99,000)	21		24
25	Fund Raising, Advertising and Promotional	(71,702)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(447,831)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (779,711)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(407,344)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (407,344)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,187,054)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Renaissance At Hillside

ID# 0042176

Report Period Beginning: 01/01/03

Ending: 12/31/03

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Il Council on LTC - COPE	$ (2,244)	20	1
2	Trust Fees (Building Co)	(680)	20	2
3	Legal & Accounting Fees (Building Co)	(4,782)	19	3
4	Bank Charges (Building Co)	(12)	20	4
5	Management Fees (Building Co)	(37,564)	17	5
6	Non-Allowable Salary	(35,868)	21	6
7	Part B Therapy Co-Insurance Write-Offs	(21,793)	21	7
8	Marketing Salary	(138,833)	43	8
9	Non-Allowable Management Fees	(142,500)	21	9
10	Legal Fees (Non-allowable & Prior Period)	(23,475)	19	10
11	Seminar Expense (Marketing)	(38)	24	11
12	Bank Charges	(17,942)	21	12
13	Cable TV	(9,377)	05	13
14	Miscellaneous Income-Office	(5,241)	21	14
15	RE Tax Expense - School	(7,010)	33	15
16	Miscellaneous Income-Food	(472)	02	16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
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96				96
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98				98
99				99
100				100
101	**Total**	(447,831)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Renaissance At Hillside # 0042176 Report Period Beginning: 01/01/03 Ending: 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(763)											(763)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(9,377)		280									(9,097)	5
6	Maintenance			1,280									1,280	6
7	Other (specify):*			(23)									(23)	7
8	**TOTAL General Services**	(10,140)		1,537									(8,603)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			129									129	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation			2									2	14
15	Other (specify):*			15									15	15
16	**TOTAL Health Care and Programs**			146									146	16
	C. General Administration													
17	Administrative	(37,564)	37,564	16,750	(242,284)	(3,824)	(66,444)						(295,802)	17
18	Directors Fees													18
19	Professional Services	(28,257)	4,782	1,052		87	1,400						(20,936)	19
20	Fees, Subscriptions & Promotions	(91,053)	692	941		(166)							(89,586)	20
21	Clerical & General Office Expenses	(327,471)		100,499		1,241	1,500						(224,231)	21
22	Employee Benefits & Payroll Taxes	(35,813)											(35,813)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(38)		520		40							522	24
25	Other Admin. Staff Transportation			179									179	25
26	Insurance-Prop.Liab.Malpractice			371									371	26
27	Other (specify):*			21,978	2,118	2,896	1,140						28,132	27
28	**TOTAL General Administration**	(520,196)	43,038	142,290	(240,166)	274	(62,404)						(637,165)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(530,337)	43,038	143,973	(240,166)	274	(62,404)						(645,622)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Renaissance At Hillside # 0042176 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(103,509)	259,317	2,164									157,971	30
31	Amortization of Pre-Op. & Org.		3,632										3,632	31
32	Interest	(22)	550,318	(583)		(14)							549,699	32
33	Real Estate Taxes	(7,010)											(7,010)	33
34	Rent-Facility & Grounds		(1,120,862)	8,549									(1,112,313)	34
35	Rent-Equipment & Vehicles			5,474									5,474	35
36	Other (specify):*													36
37	**TOTAL Ownership**	(110,541)	(307,595)	15,604		(14)							(402,546)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers			(53)									(53)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(138,833)											(138,833)	43
44	**TOTAL Special Cost Centers**	(138,833)		(53)									(138,886)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(779,711)	(264,557)	159,524	(240,166)	260	(62,404)						(1,187,054)	45

Facility Name & ID Number Renaissance At Hillside # 0042176 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				Hillside Limited Partnership		
				Building Partnership		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 1,120,862	Hillside Limited Partnership	100.00%	$	$ (1,120,862)	1
2	V	31	Amortization		Hillside Limited Partnership	100.00%	3,632	3,632	2
3	V	30	Depreciation		Hillside Limited Partnership	100.00%	259,317	259,317	3
4	V	20	Trust Fees		Hillside Limited Partnership	100.00%	680	680	4
5	V	19	Legal & Accounting		Hillside Limited Partnership	100.00%	4,782	4,782	5
6	V	32	Interest Expense-NH		Hillside Limited Partnership	100.00%	550,318	550,318	6
7	V	20	Bank Charges		Hillside Limited Partnership		12	12	7
8	V	17	Management Fees		Hillside Limited Partnership		37,564	37,564	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,120,862			$ 856,305	$ * (264,557)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance At Hillside # 0042176 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	NUCARE SERVICES CORP.	100.00%	$ 280	$ 280	15
16	V	6	REPAIRS AND MAINT.				1,280	1,280	16
17	V	7	EMPLOYEE BEN. GEN. SERV.				(23)	(23)	17
18	V	10	NURSING ADMIN.				129	129	18
19	V	14	PROGRAM TRANSPORTATION				2	2	19
20	V	15	HEALTHCARE EMPLOYEE BEN.				15	15	20
21	V	17	ADMINISTRATIVE - NON-OWNER				16,750	16,750	21
22	V	19	PROFESSIONAL FEES				1,052	1,052	22
23	V	20	FEES SUBSCRIPTIONS				941	941	23
24	V	21	CLERICAL & GENERAL				100,499	100,499	24
25	V	24	SEMINARS AND EDUCATION				520	520	25
26	V	25	ADMIN. STAFF TRAVEL				179	179	26
27	V	26	INSURANCE				371	371	27
28	V	27	EMPLOYEE BEN. GEN. ADMIN.				21,978	21,978	28
29	V	30	DEPRECIATION				2,164	2,164	29
30	V	32	INTEREST EXPENSE				(583)	(583)	30
31	V	34	BUILDING RENT				8,549	8,549	31
32	V	35	EQUIPMENT RENTAL				5,474	5,474	32
33	V	39	ANCILLARY				(53)	(53)	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 159,524	$ * 159,524	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance At Hillside # 0042176 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMIN. - R. HARTMAN	$	NUCARE SERVICES CORP.	100.00%	$ 14,543	$ 14,543	15
16	V	17	ADMIN. - B. CARR				11,939	11,939	16
17	V	17	ADMIN. - D. HARTMAN				3,047	3,047	17
18	V	17	ADMIN. - E. DICKMAN				277	277	18
19	V								19
20	V	27	EMP. BEN. - R. HARTMAN				1,288	1,288	20
21	V	27	EMP. BEN. - B. CARR				569	569	21
22	V	27	EMP. BEN. - D. HARTMAN				238	238	22
23	V	27	EMP. BEN. - E. DICKMAN				23	23	23
24	V								24
25	V	17	MANAGEMENT FEES	272,090				(272,090)	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 272,090			$ 31,924	$ * (240,166)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance At Hillside # 0042176 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMINISTRATIVE	$	CAREPATH HEALTH NETWORK	100.00%	$ 13,276	$ 13,276	15
16	V	19	PROFESSIONAL FEES				87	87	16
17	V	20	FEES, SUBSCRIPTIONS				(166)	(166)	17
18	V	21	CLERICAL AND GENERAL				1,241	1,241	18
19	V	24	SEMINARS				40	40	19
20	V	27	GEN ADMIN.- EMP. BEN.				2,896	2,896	20
21	V	32	INTEREST EXPENSE				(14)	(14)	21
22	V								22
23	V								23
24	V	17	MANAGEMENT FEES	17,100				(17,100)	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 17,100			$ 17,360	$ * 260	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance At Hillside # 0042176 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	J. RAJCHENBACH-COMP.	$	JLR MANAGEMENT CORP.	100.00%	$ 61,056	$ 61,056	15
16	V	19	PROFESSIONAL FEES				1,400	1,400	16
17	V	21	OFFICE				1,500	1,500	17
18	V	27	PAYROLL TAXES				1,140	1,140	18
19	V								19
20	V								20
21	V								21
22	V	17	MANAGEMENT FEES	127,500				(127,500)	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 127,500			$ 65,096	$ * (62,404)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance At Hillside # 0042176 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V		22	WORKMANS COMP	$ 55,129	DIAMOND INSURANCE		$ 55,129	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$ 55,129			$ 55,129	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance At Hillside # 0042176 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance At Hillside # 0042176 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance At Hillside # 0042176 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance At Hillside # 0042176 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance At Hillside # 0042176 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Bernard Hollander	Owner	Administrative	25.00%	See Attached	2.00	3.08%		$		1
2	Jack Rajchenbach	Owner	Administrative	25.00%	See Attached	7.00	10.77%	Alloc-JLR	61,056	17-7	2
3	Robert Hartman	Owner	Administrative	20.05%	See Attached	2.89	5.78%	Alloc-NuCare	14,543	17-7	3
4	David Hartman	Relative	Administrative	0%	See Attached	0.60	1.25%	Alloc-NuCare	3,047	17-7	4
5	Eitan Dickman	Relative	Administrative	0%	See Attached	0.27	0.62%	Alloc-NuCare	277	17-7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 78,923		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance At Hillside # 0042176 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance At Hillside # 0042176 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: NUCARE SERVICES CORP.
Street Address: 6677 N LINCOLN AVENUE
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 933-2600
Fax Number: (847) 933-2601

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	AVAIL. CENSUS DAYS	755,108	9	$ 3,469	$	61,008	$ 280	1
2	6	REPAIRS AND MAINT.	AVAIL. CENSUS DAYS	755,108	9	15,840	(985)	61,008	1,280	2
3	7	EMPLOYEE BEN. GEN. SERV.	AVAIL. CENSUS DAYS	755,108	9	(289)		61,008	(23)	3
4	10	NURSING ADMIN.	AVAIL. CENSUS DAYS	755,108	9	1,600	1,600	61,008	129	4
5	14	PROGRAM TRANSPORTATION	AVAIL. CENSUS DAYS	755,108	9	19		61,008	2	5
6	15	HEALTHCARE EMPLOYEE BE	AVAIL. CENSUS DAYS	755,108	9	180		61,008	15	6
7	17	ADMINISTRATIVE - NON-OWN	AVAIL. CENSUS DAYS	755,108	9	207,317	202,582	61,008	16,750	7
8	19	PROFESSIONAL FEES	AVAIL. CENSUS DAYS	755,108	9	13,022		61,008	1,052	8
9	20	FEES SUBSCRIPTIONS	AVAIL. CENSUS DAYS	755,108	9	11,642		61,008	941	9
10	21	CLERICAL & GENERAL	AVAIL. CENSUS DAYS	755,108	9	1,243,897	1,034,436	61,008	100,499	10
11	24	SEMINARS AND EDUCATION	AVAIL. CENSUS DAYS	755,108	9	6,435		61,008	520	11
12	25	ADMIN. STAFF TRAVEL	AVAIL. CENSUS DAYS	755,108	9	2,216		61,008	179	12
13	26	INSURANCE	AVAIL. CENSUS DAYS	755,108	9	4,598		61,008	371	13
14	27	EMPLOYEE BEN. GEN. ADMIN	AVAIL. CENSUS DAYS	755,108	9	272,029		61,008	21,978	14
15	30	DEPRECIATION	AVAIL. CENSUS DAYS	755,108	9	26,781		61,008	2,164	15
16	32	INTEREST EXPENSE	AVAIL. CENSUS DAYS	755,108	9	(7,220)		61,008	(583)	16
17	34	BUILDING RENT	AVAIL. CENSUS DAYS	755,108	9	105,808		61,008	8,549	17
18	35	EQUIPMENT RENTAL	AVAIL. CENSUS DAYS	755,108	9	67,754		61,008	5,474	18
19	39	ANCILLARY	AVAIL. CENSUS DAYS	755,108	9	(652)	(1,593)	61,008	(53)	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,974,446	$ 1,236,040		$ 159,524	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance At Hillside # 0042176 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: NUCARE SERVICES CORP.
Street Address: 6677 N LINCOLN AVENUE
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 933-2600
Fax Number: (847) 933-2601

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMIN. - R. HARTMAN	AVG. HOURS WORKED	36	9	180,000	180,000	2.89	14,543	1
2	17	ADMIN. - B. CARR	AVG. HOURS WORKED	48	9	180,000	180,000	3.15	11,939	2
3	17	ADMIN. - D. HARTMAN	AVG. HOURS WORKED	8	9	40,623	40,000	0.60	3,047	3
4	17	ADMIN. - E. DICKMAN	AVG. HOURS WORKED	17	9	17,157	17,000	0.27	277	4
5										5
6	27	EMP. BEN. - R. HARTMAN	AVG. HOURS WORKED	36	9	15,944		2.89	1,288	6
7	27	EMP. BEN. - B. CARR	AVG. HOURS WORKED	48	9	8,574		3.15	569	7
8	27	EMP. BEN. - D. HARTMAN	AVG. HOURS WORKED	8	9	3,170		0.60	238	8
9	27	EMP. BEN. - E. DICKMAN	AVG. HOURS WORKED	17	9	1,411		0.27	23	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 446,879	$ 417,000		$ 31,924	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance At Hillside # 0042176 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CAREPATH HEALTH NETWORK
Street Address: 6633 N LINCOLN AVENUE
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (888) 707-6700
Fax Number: (847) 679-2150

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATIVE	CARE PATH FEES	339,037	13	$ 263,221	$ 263,221	17,100	$ 13,276	1
2	19	PROFESSIONAL FEES	CARE PATH FEES	339,037	13	1,730		17,100	87	2
3	20	FEES, SUBSCRIPTIONS	CARE PATH FEES	339,037	13	(3,296)		17,100	(166)	3
4	21	CLERICAL AND GENERAL	CARE PATH FEES	339,037	13	24,604		17,100	1,241	4
5	24	SEMINARS	CARE PATH FEES	339,037	13	784		17,100	40	5
6	27	GEN ADMIN.- EMP. BEN.	CARE PATH FEES	339,037	13	57,412		17,100	2,896	6
7	32	INTEREST EXPENSE	CARE PATH FEES	339,037	13	(286)		17,100	(14)	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 344,169	$ 263,221		$ 17,360	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance At Hillside # 0042176 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: JLR MANAGEMENT CORP.
Street Address: 6633 NORTH LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 679-9141
Fax Number: (847) 679-1820

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	J. RAJCHENBACH-COMP.	AVG. HOURS WORKED	55	10	$ 479,725	$ 179,725	7	$ 61,056	1
2	19	PROFESSIONAL FEES	AVG. HOURS WORKED	55	10	11,000		7	1,400	2
3	21	OFFICE	AVG. HOURS WORKED	55	10	11,782	9,614	7	1,500	3
4	27	PAYROLL TAXES	AVG. HOURS WORKED	55	10	8,956		7	1,140	4
5										5
6										6
7	17	MARVIN NEEDLE-CONS. FEES	AVG. HOURS WORKED	40	1	36,296				7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 547,759	$ 189,339		$ 65,096	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance At Hillside # 0042176 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DIAMOND INUSRANCE
Street Address: 40 SKOKIE BLVD SUITE 105
City / State / Zip Code: NORTHBROOK, IL 60062
Phone Number: (847) 559-1002
Fax Number:

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	WORKMANS COMP	DIRECT ALLOCATION			$	$		$ 55,129	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 55,129	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance At Hillside # 0042176 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance At Hillside # 0042176 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance At Hillside # 0042176 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance At Hillside # 0042176 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance At Hillside # 0042176 Report Period Beginning: 01/01/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Cole Taylor Bank		X	Mortgage			$	$ 7,559,264			$ 550,318	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	Due to Shareholder	X						450,000			144,511	6
7	Hillside Limited Partnership										12,999	7
8	See Supplemental Schedule										25,401	8
9	TOTAL Facility Related						$	$ 8,009,264			$ 733,230	9
	B. Non-Facility Related*											
10												10
11	Allocation Interest for AL										(33,837)	11
12	Interest Income										(22)	12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ (33,859)	14
15	TOTALS (line 9+line14)						$	$ 8,009,264			$ 699,370	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$ 0** **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

SEE ACCOUNTANTS' COMPILATION REPORT

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Renaissance At Hillside # 0042176 Report Period Beginning: 01/01/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8	Sun Joint Venture		X				$	$			$ 25,998	8
9	NuCare Allocation		X								(583)	9
10	CarePath Allocation		X								(14)	10
11												11
12												12
13												13
14	TOTAL Working Capital										25,401	14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Renaissance At Hillside # 0042176 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2002 report.	$	273,485	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	462,606	2
3. Under or (over) accrual (line 2 minus line 1).	$	189,121	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$	151,344	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	340,465	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1998	313,908	8
	1999	365,376	9
	2000	382,965	10
	2001	406,970	11
	2002	462,606	12

See Attached

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Renaissance At Hillside COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0042176

CONTACT PERSON REGARDING THIS REPORT : Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	15-17-101-014-0000	Long Term Care Property	$ 462,606.32	$ 310,871.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 462,606.32	$ 310,871.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Renaissance At Hillside COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0042176

CONTACT PERSON REGARDING THIS REPORT : Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Renaissance At Hillside # 0042176 Report Period Beginning: 01/01/03 Ending: 12/31/03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 50,306 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Hillside Assisted Living Center, Ltd. Assisted Living Center 27,945 Square Feet-Combined for Assisted Living and Child Day Care
Hillside Motessori School Child Day Care

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 124,111
2. Number of Years Over Which it is Being Amortized: 10
3. Current Period Amortization: 11,154
4. Dates Incurred: 01/01/97-06/30/97

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	87,678	1995	$ 586,500	1
2					2
3	TOTALS	87,678		$ 586,500	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance At Hillside # 0042176 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1997	12,990		20	650	650	4,184	9
10	Various			1998	40,341		20	2,017	2,017	11,142	10
11	Various			1999	52,100		20	2,606	2,606	11,975	11
12								-		-	12
13								-		-	13
14								-		-	14
15								-		-	15
16								-		-	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Renaissance At Hillside # 0042176 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)		6,595,748	259,317		188,450	(70,867)	1,473,270	67
68	Related Party Allocations (Pages 12-REP & 12A-REP)		1,925	76		97	21	432	68
69	Financial Statement Depreciation			61,058			(61,058)		69
70	TOTAL (lines 4 thru 69)		$ 6,703,104	$ 320,451		$ 193,820	$ (126,631)	$ 1,501,003	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Renaissance At Hillside # 0042176 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 6,703,104	$ 320,451		$ 193,820	$ (126,631)	$ 1,501,003	1
2	Remodel 2 Bthrm	2000	2,970		20	149	149	583	2
3	Canopy Cover	2000	4,600		20	230	230	901	3
4	Repair Walk-In Coolr	2000	915		20	46	46	184	4
5	American Healh Care	2000	488		20	24	24	97	5
6	Instltn Of Landscapg	2000	9,637		20	482	482	1,687	6
7	Wallcovering	2000	3,944		20	197	197	624	7
8	Tile	2000	2,267		20	113	113	368	8
9	Screens	2000	630		20	32	32	100	9
10	2Nd Fl Improvement	2000	3,990		20	200	200	632	10
11	Power Outlet To Kitc	2000	435		20	22	22	70	11
12	Window Shades	2000	842		20	42	42	133	12
13	Landscaping	2000	985		20	49	49	173	13
14	Wallcovering	2000	5,590		20	280	280	862	14
15	Awning/Wall	2000	5,100		20	255	255	786	15
16	Electrical Panel	2000	673		20	34	34	129	16
17	Freezer	2000	520		20	26	26	104	17
18	Wallcovering	2000	(3,850)		20			3,850	18
19	Landscaping	2000	(9,637)		20			9,637	19
20	Awning	2001	3,960		20	198	198	594	20
21	Diamond Plating	2001	792		20	40	40	119	21
22	Window Treatments	2001	912		20	46	46	137	22
23	Window Treatments	2001	1,525		20	76	76	229	23
24	Dining Room Wall	2001	8,000		20	400	400	1,133	24
25	Fencing	2001	1,558		20	78	78	215	25
26	3 Doors	2001	1,272		20	64	64	180	26
27	Fencing	2001	1,558		20	78	78	208	27
28	Landscaping	2001	10,652		20	533	533	1,376	28
29	Condesor Fan Motor	2001	842		20	42	42	109	29
30	Security Locks	2001	767		20	38	38	99	30
31	Wanderguard	2001	569		20	28	28	73	31
32	Parking Lot Repair	2001	1,375		20	69	69	173	32
33	Roof Top Chiller Rep	2001	904		20	45	45	113	33
34	TOTAL (lines 1 thru 33)		$ 6,767,889	$ 320,451		$ 197,736	$ (122,715)	$ 1,526,681	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Renaissance At Hillside # 0042176 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 6,767,889	$ 320,451		$ 197,736	$ (122,715)	$ 1,526,681	1
2	Parking Lot Seal	2001	3,565		20	178	178	431	2
3	Roof Top Chiller Rep	2001	525		20	26	26	66	3
4	Awning System	2001	3,100		20	155	155	400	4
5	Compressor Motor	2001	874		20	44	44	102	5
6	Flow Switch	2001	630		20	32	32	84	6
7	Painting	2001	992		20	50	50	112	7
8	Electrical	2001	4,620		20	231	231	578	8
9	Electrical	2001	897		20	45	45	94	9
10	Circuit Breaker Repairs	2002	1,675		20	168	168	307	10
11	6 Motors/Fan Caps	2002	2,435		20	244	244	446	11
12	Air Cooled Chiller/Elec.	2002	88,400		20	8,840	8,840	14,733	12
13	Landscaping	2002	2,097		20	140	140	221	13
14	Fire Sprinkler Work	2002	1,055		20	151	151	226	14
15	Furnish/Install Lamps	2002	30,828		20	6,166	6,166	9,248	15
16	Carpet	2002	1,158		20	165	165	179	16
17	Electricwork	2002	(4,620)		20	(462)	(462)	(924)	17
18	Electricwork	2002	(897)		20	(90)	(90)	(179)	18
19	Decorating & Painting	2002	1,044		20	52	52	104	19
20	Awnings	2003	4,905		20	164	164	164	20
21	Door Access System	2003	6,000		20	450	450	450	21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,917,172	$ 320,451		$ 214,485	$ (105,966)	$ 1,553,523	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Renaissance At Hillside # 0042176 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 6,917,172	$ 320,451		$ 214,485	$ (105,966)	$ 1,553,523	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,917,172	$ 320,451		$ 214,485	$ (105,966)	$ 1,553,523	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Renaissance At Hillside # 0042176 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 6,917,172	$ 320,451		$ 214,485	$ (105,966)	$ 1,553,523	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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22									22
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,917,172	$ 320,451		$ 214,485	$ (105,966)	$ 1,553,523	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Renaissance At Hillside # 0042176 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 6,917,172	$ 320,451		$ 214,485	$ (105,966)	$ 1,553,523	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,917,172	$ 320,451		$ 214,485	$ (105,966)	$ 1,553,523	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Renaissance At Hillside # 0042176 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 6,917,172	$ 320,451		$ 214,485	$ (105,966)	$ 1,553,523	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,917,172	$ 320,451		$ 214,485	$ (105,966)	$ 1,553,523	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Renaissance At Hillside # 0042176 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 6,917,172	$ 320,451		$ 214,485	$ (105,966)	$ 1,553,523	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,917,172	$ 320,451		$ 214,485	$ (105,966)	$ 1,553,523	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Renaissance At Hillside # 0042176 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 6,917,172	$ 320,451		$ 214,485	$ (105,966)	$ 1,553,523	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,917,172	$ 320,451		$ 214,485	$ (105,966)	$ 1,553,523	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Renaissance At Hillside # 0042176 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 6,917,172	$ 320,451		$ 214,485	$ (105,966)	$ 1,553,523	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
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18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,917,172	$ 320,451		$ 214,485	$ (105,966)	$ 1,553,523	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Renaissance At Hillside # 0042176 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		$ 6,917,172	$ 320,451		$ 214,485	$ (105,966)	$ 1,553,523	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,917,172	$ 320,451		$ 214,485	$ (105,966)	$ 1,553,523	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Renaissance At Hillside # 0042176 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	168			1997	$ 6,595,748	$ 259,317		$ 188,450	$ (70,867)	$ 1,473,270	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-BLDG, Line 70 for total

Facility Name & ID Number Renaissance At Hillside # 0042176 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 6,595,748	$ 259,317		$ 188,450	$ (70,867)	$ 1,473,270	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Renaissance At Hillside # 0042176 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	NuCare Allocation			1997	372	10	35	19	9	116	9
10	NuCare Allocation			1998	326	8	35	16	8	89	10
11	NuCare Allocation			1999	457	39	35	23	(16)	101	11
12	NuCare Allocation			2000	555	14	35	28	(14)	95	12
13	NuCare Allocation			2001	215	5	35	11	6	31	13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

Facility Name & ID Number Renaissance At Hillside # 0042176 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,925	$ 76		$ 97	$ (7)	$ 432	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Renaissance At Hillside # 0042176 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 616,693	$ 61,531	$ 62,921	$ 1,390	10	$ 322,535	71
72	Current Year Purchases	47,411	33	2,253	2,220	10	2,253	72
73	Fully Depreciated Assets	14,771	101	101		10	14,771	73
74								74
75	TOTALS	$ 678,875	$ 61,665	$ 65,275	$ 3,610		$ 339,559	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		98 CHEVY VAN	2001	$ 11,532	$ 2,306	$ 1,153	$ (1,153)	5	$ 2,786	76
77										77
78										78
79										79
80	TOTALS			$ 11,532	$ 2,306	$ 1,153	$ (1,153)		$ 2,786	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 8,194,079	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 384,422	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 280,913	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (103,509)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,895,868	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

SEE ACCOUNTANTS' COMPILATION REPORT

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Renaissance At Hillside # 0042176 Report Period Beginning: 01/01/03 Ending: 12/31/03

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	NuCare Allocation				8,549			5
6								6
7	TOTAL				$ 8,549 **			7

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 13,355 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance At Hillside # 0042176 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$ 325	$	$ 325
2	Books and Supplies		265		265
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$ 590	$	$ 590
10	SUM OF line 9, col. 1 and 2 (e)	$ 590			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance At Hillside # 0042176 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 140,386	$		$ 140,386	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			35,097			35,097	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			175,482			175,482	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				203,879		203,879	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental			8,651			122,622		131,273	13
14	TOTAL			$ 8,651		$ 350,965	$ 326,501		$ 686,117	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance At Hillside # 0042176 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/03 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 2,000	$ 2,000	1
2	Cash-Patient Deposits	5,124	5,124	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	954,433	954,433	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	121,117	121,117	6
7	Other Prepaid Expenses	138,040	138,040	7
8	Accounts Receivable (owners or related parties)	1,412,490	1,412,490	8
9	Other(specify): See Attached Schedule	(144,334)	2,224,700	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,488,870	$ 4,857,904	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		238,723	13
14	Buildings, at Historical Cost		6,193,366	14
15	Leasehold Improvements, at Historical Cost	633,678	633,678	15
16	Equipment, at Historical Cost	669,424	669,424	16
17	Accumulated Depreciation (book methods)	(796,621)	(1,905,063)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	37,608	37,608	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(12,536)	(12,536)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	2,301	122,471	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 533,854	$ 5,977,671	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,022,724	$ 10,835,575	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,338,345	$ 1,338,345	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	8,403	8,403	28
29	Short-Term Notes Payable	450,000	450,000	29
30	Accrued Salaries Payable	123,484	123,484	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,977	10,977	31
32	Accrued Real Estate Taxes(Sch.IX-B)	151,344	151,344	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	2,731,548	2,731,548	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,814,101	$ 4,814,101	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		7,559,264	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 7,559,264	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,814,101	$ 12,373,365	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,791,377)	$ (1,537,790)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,022,724	$ 10,835,575	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Renaissance At Hillside # 0042176 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,867,580)	1
2	Restatements (describe):		2
3	Adjusting Journal Entries 12/31/02	(24,120)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,891,700)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	100,323	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 100,323	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,791,377)	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance At Hillside # 0042176 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,910,296	1
2	Discounts and Allowances for all Levels	(779,479)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,130,817	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	934,402	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 934,402	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	324,162	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	28,318	19
20	Radiology and X-Ray	4,570	20
21	Other Medical Services	70,039	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 427,089	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	21	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 21	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule		28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,492,329	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,111,852	31
32	Health Care	2,607,619	32
33	General Administration	2,006,728	33
	B. Capital Expense		
34	Ownership	1,749,345	34
	C. Ancillary Expense		
35	Special Cost Centers	824,950	35
36	Provider Participation Fee	91,512	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,392,006	40
41	**Income before Income Taxes (line 30 minus line 40)****	100,323	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 100,323	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** Cash Basis **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** SEE ACCOUNTANTS' COMPILATION REPORT

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Renaissance At Hillside # 0042176 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,993	2,142	$ 81,907	$ 38.24	1
2	Assistant Director of Nursing	1,582	2,086	60,918	29.20	2
3	Registered Nurses	8,693	9,594	300,883	31.36	3
4	Licensed Practical Nurses	36,876	40,186	770,358	19.17	4
5	Nurse Aides & Orderlies	79,855	84,243	781,391	9.28	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	364	364	8,651	23.77	7
8	Rehab/Therapy Aides					8
9	Activity Director	2,801	3,344	48,589	14.53	9
10	Activity Assistants	6,749	7,172	55,731	7.77	10
11	Social Service Workers	3,828	4,108	102,620	24.98	11
12	Dietician	2,077	2,202	40,301	18.30	12
13	Food Service Supervisor					13
14	Head Cook	9,600	10,495	105,991	10.10	14
15	Cook Helpers/Assistants	16,594	17,285	127,415	7.37	15
16	Dishwashers					16
17	Maintenance Workers	1,309	1,438	18,868	13.12	17
18	Housekeepers	25,267	27,580	235,277	8.53	18
19	Laundry					19
20	Administrator	2,028	2,028	85,536	42.18	20
21	Assistant Administrator					21
22	Other Administrative	1,028	1,028	52,443	51.01	22
23	Office Manager					23
24	Clerical	7,475	7,475	130,517	17.46	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,052	3,364	69,536	20.67	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	4,565	4,565	138,834	30.41	33
34	TOTAL (lines 1 - 33)	215,736	230,699	$ 3,215,766 *	$ 13.94	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly Fee	$ 8,440	01-03	35
36	Medical Director	Monthly Fee	18,750	09-03	36
37	Medical Records Consultant	Monthly Fee	4,128	10-03	37
38	Nurse Consultant	313	7,821	10-03	38
39	Pharmacist Consultant	Monthly Fee	3,648	10-03	39
40	Physical Therapy Consultant	75	3,735	10a-03	40
41	Occupational Therapy Consultant	38	1,882	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	23	1,138	10a-03	43
44	Activity Consultant	46	2,459	11-03	44
45	Social Service Consultant	82	4,320	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	577	$ 56,321		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	656	$ 24,290	10-03	50
51	Licensed Practical Nurses	1,899	63,944	10-03	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	2,555	$ 88,234		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance At Hillside # 0042176 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Colleen Kamin (01/01/03-06/15/03)	Administrator	0	$ 53,512
Aaron Topper (08/18/03-12/31/03)	Administrator	0	32,024
David Schechter	Executive Admin	0	31,717
Kathy Brander	Dir of Reg Mgmt	0	8,371
Rusti Bauman	VP of Medicare Reimb	0	1,188
Marilyn Flaherty	VP of Medicare Reimb	0	1,580
See Supplemetal Schedule			9,587
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 137,979

B. Administrative - Other

Description	Amount
NuCare Services	$ 272,090
CarePath Network Fees	17,100
JLR Management	127,500
TOTAL (agree to Schedule V, line 17, col. 3)	$ 416,690

(Attach a copy of any management service agreement)

C. Professional Services

Vendor/Payee	Type	Amount
FR&R	Accounting	$ 30,629
Dan Foley CPA	Accounting	200
Personnel Planners	Unemployment Consulting	2,185
Purchasing Plus	Purchasing Services	600
C&C Communications	Computer	296
CDW Computer	Computer	573
Chris Novotny	Computer	83
Giftrap Corp	Computer	5,370
HDSI	Computer	6,312
Ivans	Computer	299
Medicom	Computer	821
See Supplemetal Schedule		70,664
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 118,033

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 55,129
Unemployment Compensation Insurance	56,669
FICA Taxes	235,347
Employee Health Insurance	84,599
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Union Pension Benefits	26,768
Union Health Insurance	55,628
401K Plan	3,515
Employee Benefits	20,533
TOTAL (agree to Schedule V, line 22, col.8)	$ 538,188

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	20,467
Health Care Worker Background Check (Indicate # of checks performed 221)	1,858
ILCouncil on LTC Dues	6,203
Dues & Subscriptions	340
License & Fees	2,393
NuCare Allocation	941
Care Path Allocation	(166)
See Supplemental Schedule	71,702
Less: Public Relations Expense	( )
Non-allowable advertising	(71,702)
Yellow page advertising	(834)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 31,402

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,245
NuCare Allocation	520
CarePath Allocation	40
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,805

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Renaissance At Hillside # 0042176 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance At Hillside # 0042176 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IL Council on LTC - $ 8,447.40**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **46,144** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **91,512**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **Yes** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100%In14**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.